The clinical documentation specialist’s role is, through medical record review, to capture pertinent clinician documentation while the patient is in the hospital. The next step, if needed, is to submit a request (query) to clinicians for clarification or additional documentation that would permit assignment of a more precise code. A CDS should conduct verbal discussions with clinicians whenever possible for more effective communication.

Collaboration and exchange of information between a CDS and an inpatient coder are necessary to ensure that the clinician documentation is actually translated into the codes that reflect the patient’s condition. The CDS also facilitates clinician education by giving brief presentations at medical staff meetings and conferences as well as by having direct conversations with clinicians.

Inpatient coders must not only collaborate with the CDS but must also be trained in the clinical terminology and diagnostic criteria most often encountered in the CDI process. There are almost always opportunities to improve code selection, sequencing, and application of coding guidelines.

Coders typically report through the medical records department to the hospital’s chief financial officer, and a CDS frequently reports through care management to nursing. For an effective CDI program, managers must ensure close collaboration, consensus processes and definitions, and shared values and objectives. Too often divisiveness and conflict prevail. As an alternative, a unified reporting structure for both coders and CDS can mitigate this dilemma.

Best practices require that a CDI physician advisor, often a hospitalist, support the CDI program. The role of a fully engaged CDI advisor is outlined in Table 3.

In summary, a clinical documentation improvement program is a comprehensive, multi-disciplinary effort that includes the medical staff, clinical documentation specialists, inpatient coders, and CDI physician advisors. It is designed to ensure documentation of diagnostic and procedural terminology needed for accurate translation of clinical work into the precise codes that best describe the severity of illness of patients and the complexity of care provided to them.

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**LETTER TO THE EDITOR: READER DISAGREES ABOUT KEFIR FOR C. DIFF**

After reading the article “A tasty solution to recurrent *Clostridium difficile*” (ACP Hospitalist, September 2014), I can’t help but have a few concerns. The writer describes a novel practice by Johan S. Bakken, MD, FACP, at the University of Minnesota for the treatment of recurrent *C. difficile* infections: a long oral vancomycin taper over many weeks and ingestion of kefir probiotic with every meal.

While I understand that the small number of patients selected for Dr. Bakken’s mini-trial could not have fecal transplants for various reasons, I do not agree with the use of kefir as an adjunctive treatment. Kefir contains the usual probiotic preparations (*Lactobacillus, Streptococcus, Saccharomyces, Bifidobacterium*, etc.), which have been shown to cause adverse events (septic shock, fungemia, intra-abdominal abscesses). Although these effects are rare, they are well documented in the medical literature and should probably be avoided altogether in patients with compromised bowel integrity, like Dr. Bakken’s.

Some recent large meta-analyses and reviews have shown some benefit with probiotics for prevention of antibiotic-associated diarrhea, with subgroup analyses of *C. difficile*-associated diarrhea showing the same. However, the studies included in these reviews were of marginal to poor quality (inconsistent probiotic preparation, large heterogeneity, inconsistent reporting of conflict of interest, failure to report adverse events). In contrast, a recent large, double-blind, randomized, placebo-controlled trial (PLACIDE) showed no benefit of probiotics for prevention of antibiotic-associated diarrhea. Although this trial did not specifically investigate probiotics and *C. difficile*-associated diarrhea, it was well controlled and well powered and reported consistent probiotic preparations and adverse events.

According to the Infectious Diseases Society of America (IDSA), there are no convincing data supporting the use of probiotic agents for preventing or treating primary or recurrent *C. difficile* infections. There are some data on the use of *Saccharomyces boulardii* in conjunction with oral vancomycin therapy for recurrent *C. difficile* infections, but the IDSA recommends avoiding this therapy in critically ill patients.

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**CODING CORNER**

**Table 3. Tasks of physician advisors in clinical documentation improvement programs**

- Review records referred by the clinical documentation improvement (CDI) team in a timely manner
- Resolve clinical documentation specialist/coder mismatches of diagnosis-related groups
- Support engagement of medical staff
- Provide medical staff CDI education and information
- Contribute to CDI program performance improvement

In summary, a clinical documentation improvement program is a comprehensive, multi-disciplinary effort that includes the medical staff, clinical documentation specialists, inpatient coders, and CDI physician advisors. It is designed to ensure documentation of diagnostic and procedural terminology needed for accurate translation of clinical work into the precise codes that best describe the severity of illness of patients and the complexity of care provided to them.

*Dr. Pinson is a certified coding specialist and cofounder of HCQ Consulting (www.hcqconsulting.com) in Houston. This content is adapted with permission from HCQ Consulting.*